FAIRFAX COUNTY HEALTH DEPARTMENT
INTERNATIONAL TRAVEL CLINIC

NAME: _____ **AGE:** _____ **TODAY'S DATE:** _____

LAST, FIRST **LMP:** _____

DATE OF DEPARTURE: _____ **HOW LONG WILL YOU BE GONE?** _____

REASON FOR TRIP: **TOURIST:** ❑ **BUSINESS:** ❑ **OTHER:** ❑

DO YOU PLAN TO TRAVEL OUTSIDE OF MAJOR CITIES? _____

ITINERARY (List Countries to be visited in order): _____

_____

DO NOT WRITE BELOW THIS LINE
VACCINATION PLAN
This does not take the place of an Official Record of Vaccines

DATE	DISEASE/ VACCINE	DURATION OF PROTECTION		DATE	DISEASE/ VACCINE	DURATION OF PROTECTION
	Tetanus Diptheria (Td)	**10 years**			**Meningococcal Meningitis**	**3 years**
	Measles, Mumps, Rubella (MMR) *Series of 2*	**Lifetime**			**Hepatitis A (Havrix)** *Series of 2*	**Lifetime**
	Polio: OPV or IPV	**Lifetime, after booster**			**Immune/Gamma Globulin** *For prevention of Hepatitis A*	**3 months**
	Yellow Fever	**10 years**			**Hepatitis B** *Series of 3*	**Lifetime**
	Typhoid: Oral *(Must be a least 6 years old)*	**5 years**			**Japanese Encephalitis** *Series of 3*	**Unknown 2 or 3 years**
	Typhoid: Injectable ViCPS *(Must be at least 2 years old)*	**2 years**			**Flu**	**1 year**
	Malaria	**Per trip**			**Rabies** *Series of 3*	**Booster every 2 years**

RETURN DATE	VACCINE NEEDED